State Legislative Status Report
2007-2008 Regular Session
May 21, 2008

Note: Status information reflects information available as of 05/20/2008.

ASSEMBLY BILLS

AB 1 (Laird) Health care coverage.
Version: Amended 09/07/2007
Sponsor: 100% Campaign; People Improving Communities through Organizing (PICO)
Status: 09/12/2007-Held at ASSEMBLY DESK.

Note: AB 1 is identical to SB 32 (Steinberg).

The bill would:
- Expand eligibility for Medi-Cal and the Healthy Families Program (HFP) to cover children in families with household income up to 300% FPL from the current limit of 250% FPL.
- Create the Healthy Families Buy-In Program that would be administered by the MRMIB; the bill would make unsubsidized HFP coverage available to children whose household income exceeds 300% of the federal poverty level and who meet other specified criteria.
- Delete specified citizenship and immigration status requirements for Medi-Cal and HFP and would require the MRMIB to implement a process permitting applicants to self-certify income and income deductions by January 1, 2008.
- Require the MRMIB and the Department of Health Care Services to take actions to improve and coordinate the application and enrollment process for Medi-Cal and the HFP and develop a process to transition the enrollment of children from local children's health initiatives into Medi-Cal and HFP.
- Establish the HFP to Medi-Cal Presumptive Eligibility Program, the Medi-Cal to HFP Presumptive Eligibility Program, the Med-Cal Presumptive Eligibility Program and the HFP Presumptive Eligibility Program.
- Deem children who have a California Children's Services (CCS) eligible medical condition and who are enrolled in the HFP or the HFP Buy-In Program to be financially eligible for CCS program benefits.

AB 2 (Dymally) Health care coverage.
Version: Amended 09/07/2007
Sponsor: Author
Status: 09/11/2007-Senate Floor INACTIVE FILE.

Note: MRMIB support.

This bill would:
- Require insurers in all markets to either sell individual coverage on a guaranteed issuance basis with community rating (no rating for age, health status or geography) or elect to pay a fee to help finance the Major Risk Medical Insurance Program (MRMIP).

**New status since last board meeting*
***New bill since last board meeting*

- Require health plans and insurers to either pay a per life fee, adjusted by MRMIB and capped at $1.50 per life, to fully fund the MRMIP, eliminating any wait lists for the program, or agree to provide coverage to persons eligible for the MRMIP, based on their market-share of covered lives in the state.
- As of January 1, 2008, eliminate annual benefit caps for the MRMIP and require at least $1 million lifetime benefit cap; cap out-of-pocket costs at $2,500 or lower per person and $4,000 per family, and; reduce consumer costs for primary and preventative care and medications for chronic conditions.
- Require MRMIB to appoint an 8-member advisory committee (volunteers) to advise the board on topics related to operation of the program and improving quality and cost-effectiveness of program operations.
- Provide coverage on or after January 1, 2009 for persons newly eligible for HIPPA through MRMIP.
- Allow, after January 1, 2009, persons enrolled in Guarantee Issue Program (GIP) coverage to enroll in MRMIP.
- Reduce subscriber premiums in MRMIP over time, based on a percent of the cost in the private market for comparable coverage: from 137% currently to 125% on January 1, 2008, and on January 1, 2009, at 120% for persons above 300% FPL and 110% for persons below 300% FPL.
- Require MRMIB to report to the Legislature by July 1, 2011 regarding implementation of the provisions of the bill, and specific information regarding program operations.

***AB 16** (Hernandez) Pupil immunizations.
Version: Amended 04/28/2008
Sponsor: Author
Status: 05/14/2008-Senate APPROPRIATIONS.

This bill changes the authority for making referrals for annual cervical cancer screening to a licensed health care practitioner providing care to the patient instead of "the patient's physician, surgeon, nurse practitioner or certified nurse midwife." The bill also requires that individual or group health plan contracts or health insurance policies issued on or after January 1, 2009 that cover the treatment or surgery of cervical cancer must also cover a vaccination for human pappillomavirus. The previous version of this bill concerned students' immunizations and all of its earlier previsions were deleted.

AB 368 (Carter) Hearing aids.
Version: Introduced 02/14/2007
Sponsor: Author
Status: 02/07/2008-Senate HEALTH.

This bill would require health care service plans and health insurers to offer or provide coverage up to $1,000 for hearing aids to all enrollees, subscribers, and the insured less than 18 years of age. The bill would provide that the requirement would not apply to certain types of insurance.

**New status since last board meeting*
***New bill since last board meeting*

AB 1150 (Lieu) Health care coverage: underwriting practices.
Version: Amended 01/16/2008
Sponsor: Author
Status: 02/07/2008-Senate HEALTH.

This bill would prohibit a health plan from compensating a person or entity based on performance goals or quotas regarding the number of contracts, policies, or certificates they helped rescind, cancel, or limit, or on the resulting cost savings to the plan or insurer.

AB 1554 (Jones) Health care coverage: rate approval.
Version: Amended 07/05/2007
Sponsor: Author
Status: 07/11/2007-Senate HEALTH.

This bill would require approval by the Department of Managed Health Care or the California Department of Insurance of an increase in the amount of the premium, co-payment, coinsurance obligation, deductible, and other charges under individual and group policies issued by health plan or health insurers. This would not include a Medicare supplement contract or policy or health plan contracts issued through a state program including Medi-Cal and the Healthy Families Program.

***AB 1774** (Lieber) Health care coverage: uterine and ovarian cancer screening tests.
Version: Amended 04/22/2008
Sponsor: Cancer Schmancer
Status: 05/22/2008-Set for hearing in Assembly APPROPRIATIONS. In suspense file.

This bill requires health insurance policies issued, amended, or renewed, on or after January 1, 2009, to provide coverage for any medically necessary test, as determined by health care providers, to screen for and diagnose gynecological cancers. Current law authorizes health plans, not providers, to make this determination. The bill further requires the test to be provided consistent with national professional standard guidelines.

***AB 1945** (De La Torre) Health care coverage.
Version: Amended 04/02/2008
Sponsor: California Medical Association
Status: 05/22/2008-Set for hearing in Assembly APPROPRIATIONS.

This bill would mandate the Director of the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) Commissioner to establish and require the use of a standard application for individual coverage. Health plans and insurers would also be required to seek and obtain the approval of their regulator before rescinding a plan contract or insurance policy. The DMHC Director and the Insurance Commissioner would be required to contract with one or more independent review organizations to review rescissions by January 1, 2010. Each regulator would be permitted to assess administrative penalties and suspend or revoke the license or certificate of a plan or insurer for violating the rescission prohibition.

**New status since last board meeting*
***New bill since last board meeting*

***AB 2088** (Beall) Public health: tobacco fees: Secretary of Addiction Prevention and Recovery Services.
Version: Amended 04/07/2008
Sponsor: Author
Status: 05/22/2008-Set for hearing in Assembly APPROPRIATIONS. In suspense file.

This bill would create a new cabinet-level Secretary of Addiction Prevention and Recovery Services who would oversee alcohol abuse and drug abuse issues in the state. It would also create the Addiction Prevention and Recovery Board within the State Department of Alcohol and Drug Programs

***AB 2549** (Hayashi) Health care coverage: notification.
Version: Amended 04/03/2008
Sponsor: Author
Status: 05/22/2008-Set for hearing in Assembly APPROPRIATIONS. In suspense file.

This bill would prohibit health plans and health insurers from rescinding an individual health insurance policy for any reason after six months from the date of its issuance. It would also permit a policyholder or insured who believes that his or her individual health insurance policy was wrongfully rescinded to request a review of the rescission by submitting a complaint to the Insurance Commissioner or the Department of Managed Health Care.

***AB 2589** (Solorio) Health care coverage: public agencies.
Version: Amended 04/22/2008
Sponsor: Santa Ana School District
Status: 05/15/2008-Senate RULES.

This bill would require health plans or health insurers to report annually to governing boards of public agencies with whom they contract the name and address of any agent, broker, or individual related to the public entity's contract or policy to whom they paid a commission or fee and the amount paid.

***AB 2847** (Krekorian) Health care coverage.
Version: Amended 04/23/2008
Sponsor: California Medical Association
Status: 05/22/2008-Set for hearing in Assembly APPROPRIATIONS. In suspense file.

This bill would require health plans and insurers, until January 1, 2014, to disprove a provider's determination of medical necessity when a plan or insurer is legally challenged about its decision to deny, delay or modify health care services. The bill also would allow treating providers, under specified conditions, to apply directly to the health plan's or insurer's regulator for independent medical review of denied, limited or delayed health care services.

***AB 2861** (Hayashi) Mental health services.
Version: Amended 04/09/2008
Sponsor: California Hospital Association
Status: 05/22/2008-Set for hearing in Assembly APPROPRIATIONS. In suspense file.

This bill would require, with exceptions, a health care service plan to reimburse providers for emergency mental health services provided to its enrollees until the enrollee is stabilized. Prior authorization would not be required as long as federal or state law require that emergency services be provided without first questioning the patient's ability to pay.

***AB 2902** (Swanson) Public health outreach: community health care workers.
Version: Amended 03/25/2008
Sponsor: Ron Dellums, Mayor of Oakland
Status: 05/22/2008-Set for hearing in Assembly APPROPRIATIONS. In suspense file.

This bill would require the Office of Multicultural Health, State Department of Public Health, to encourage the use of community-based health care workers to target underserved communities, including encouraging the Healthy Families program to use and reimburse these workers, when cost effective. The bill also conforms existing law to permit public health programs to utilize these community-based health care workers.

***AB 2967** (Lieber) Health care cost and quality transparency.
Version: Amended 04/15/2008
Sponsor: Service Employees International Union
Status: 05/22/2008-Set for hearing in Assembly APPROPRIATION. In suspense file.

This bill would create the California Health Care Cost and Quality Transparency Committee in the Health and Human Services Agency (CHHSA) to develop a plan to improve medical data collection and reporting practices. The bill would also require the CHHSA Secretary and the Committee to implement strategies to improve health care quality and meet related requirements. The Committee would establish a fee schedule and identify other financial resources to implement the bill. The bill would require an appropriation in the annual Budget Act in order to be implemented.

***AB 3027** (De Leon) Health care coverage: disclosures: foreign languages.
Version: Amended 04/02/2008
Sponsor: Latino Issues Forum
Status: 05/22/2008-Set for hearing in Assembly APPROPRIATIONS. In suspense file.

This bill would require that the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) jointly develop a "notice," on or before January 30, 2009, to inform subscribers how to access "interpretive" services to assist them in communicating with their doctor, plan or insurer. The notice would also include DMHC and CDI contact information to assist subscribers "with difficulties in, or complaints about, accessing" their health plans or insurers. The notice would be required to be written in all languages for which Medi-Cal materials are required to be written. The bill would require, on and after March 2,

**New status since last board meeting*
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2009, that health plans and health insurers distribute the document to subscribers with "annual enrollment or disenrollment correspondence, all notices and forms, and any appointment-related information," and in at least one separate mailing on June 1 of each year.

ACA 14 (Strickland) State-funded benefits.
Version: Introduced 02/22/2008
Sponsor: Author
Status: 02/25/2008-Bill read first time and printed. Bill not yet assigned to a committee.

This bill would place an initiative on the ballot which, if passed by voters, would amend the State Constitution to require that specific proof of U.S. citizenship or one's right to lawfully reside in the United States be provided as a condition of eligibility by persons 18 years of age or older applying for a non-emergency state-funded public benefit, with some exceptions. Allowable proof would be defined as a California driver's license or State-issued identification card that meets applicable document and issuance requirements of federal law, a U.S. passport, or a permanent resident alien card issued by the U.S. government.

****AJR 54** (Laird) State Children's Health Insurance Program.
Version: Amended 05/06/2008
Sponsor: 100% Campaign
Location: 05/06/2008-Assembly FLOOR third reading.

Note: MRMIB support.

This resolution would urge the President and the Congress of the United States to rescind the federal Centers for Medicare & Medicaid Services directive of August 17, 2007 that restricts states' authority to cover children under the State Children's Health Insurance Program.

**New status since last board meeting*
***New bill since last board meeting*

SENATE BILLS

SB 32 (Steinberg) Health care coverage: children.
Version: Amended 09/07/2007
Sponsor: 100% Campaign; People Improving Communities through Organizing (PICO)
Status: 09/11/2007-Assembly FLOOR INACTIVE FILE.

Note: SB 32 is identical to AB 1 (Laird).

The bill would:
- Expand eligibility for Medi-Cal and the Healthy Families Program (HFP) to cover children in families with household income up to 300% FPL from the current limit of 250% FPL.
- Create the Healthy Families Buy-In Program that would be administered by the MRMIB; the bill would make unsubsidized HFP coverage available to children whose household income exceeds 300% of the federal poverty level and who meet other specified criteria.
- Delete specified citizenship and immigration status requirements for Medi-Cal and HFP and would require the MRMIB to implement a process permitting applicants to self-certify income and income deductions by January 1, 2008.
- Require the MRMIB and the Department of Health Care Services to take actions to improve and coordinate the application and enrollment process for Medi-Cal and the HFP and develop a process to transition the enrollment of children from local children's health initiatives into Medi-Cal and HFP.
- Establish the HFP to Medi-Cal Presumptive Eligibility Program, the Medi-Cal to HFP Presumptive Eligibility Program, the Medi-Cal Presumptive Eligibility Program and the HFP Presumptive Eligibility Program.
- Deem children who have a California Children's Services (CCS) eligible medical condition and who are enrolled in the HFP or the HFP Buy-In Program to be financially eligible for CCS program benefits.

SB 697 (Yee) Health care coverage: provider charges.
Version: Amended 09/07/2007
Sponsor: Author
Status: 09/07/2007-Assembly HEALTH.

This bill would explicitly prohibit any health care provider who is given documentation that a person is enrolled in the Healthy Families program from "balance billing" the subscriber for health care services.

****SB 775** (Ridley-Thomas) Childhood lead poisoning.
Version: Amended 06/05/2007
Sponsor: Physicians For Social Responsibility, National Health Law Program
Status: 06/21/2007-Assembly HEALTH

The bill would require the Department of Public Health to make information on lead poisoning available to all health care providers that administer perinatal care services as specified, and would require providers to make this information available to pregnant women.

**New status since last board meeting*
***New bill since last board meeting*

This bill would require laboratories that test for lead poising to report findings to the Department of Health Services.

SB 840 (Kuehl) Single-payer health care coverage.
Version: Amended 07/10/2007
Sponsor: Author
Status: 07/10/2007-Assembly APPROPRIATIONS.

This bill would establish the California Healthcare System to be administered by the newly created California Healthcare Agency, under the control of a Healthcare Commissioner. The bill would make all California residents eligible for specified health care benefits under the California Healthcare System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. The bill would provide that a resident of the state with a household income at or below 200% of the federal poverty level would be eligible for the type of benefits provided under the Medi-Cal program. The bill would create several new offices to establish policy on medical issues and various other matters relating to the health care system.

SB 981 (Perata) Health care coverage: non-contracting hospital-based physician claims.
Version: Amended 09/07/2007
Sponsor: Author
Status: 09/10/2007-Re-referred to Assembly Committee on HEALTH and Assembly Committee on APPROPRIATIONS.

This bill would require health plans to pay a non-contracting hospital-based physician the lesser of the physician's full charge or the newly created "interim payment standard" as defined. The bill creates various payment rates and standards for non-contracted hospital-based physicians and for a provider dispute resolution process. It also requires the Department of Managed Health Care to develop regulations regarding payment to non-contracted hospital-based physicians serving Healthy Families and the Access to Infants and Mothers (AIM) subscribers.

***SB 1440** (Kuehl) Health care coverage.
Version: Amended 04/15/2008
Sponsor: California Medical Association
Status: 05/22/2008-Set for hearing in Senate APPROPRIATIONS. In suspense file.

Current law does not limit the amount of administrative expenses that health plans may pay with money derived from sources other than subscribers. This bill would require full-service health care service plans to spend at least 85% of the dues, fees, premiums, and other periodic payments received by the insurer on health care benefits beginning January 1, 2009. The bill would define "health care benefits" for the purpose of determining administrative expenses. The bill would require health plans and insurers, as of June 1, 2009, and then annually, to report to their regulator that they meet these requirements. It would also allow their regulator to fine or otherwise penalize them for failure to comply.

**New status since last board meeting*
***New bill since last board meeting*

***SB 1459** (Yee) Healthy Families Program.
Version: Amended 05/13/2008
Sponsor: 100% Campaign, People Improving Communities through Organizing (PICO).
Status: 05/22/2008-Set for hearing in Senate APPROPRIATIONS. In suspense file.

This bill would require the MRMIB to change existing (centralized) systems to transfer Healthy Families program eligibility determination to 58 (decentralized) county welfare departments beginning on or before July 1, 2009. It would:

- Require MRMIB to consult with the Department of Health Care Services (DHCS), and require DHCS and MRMIB to consult with stakeholders, including counties and client advocates, to change existing systems and develop procedures for the transfer.
- Allow HFP to continue to use a private vendor to collect premiums and assist with health plan selection. However, the intent is to incorporate these functions, to the extent possible, into the Medi-Cal managed care enrollment broker administered by DHCS.
- Require counties to assume full responsibility for eligibility determinations by January 1, 2010.

This bill would also create the California Health Care Program (Cal-Health) to be established by the Secretary of California Health and Human Services (CHHS) with assistance from the MRMIB and the State Department of Health Care Services (DHCS). Cal-Health would:

- Coordinate efforts to market HFP, Medi-Cal and CalHealth to persons potentially eligible for these programs;
- Permit "participating providers" to screen and enroll children into 60-day accelerated temporary coverage in HFP or Medi-Cal, to the extent allowed by federal law, and create an electronic process and systems infrastructure to perform these functions;
- Secure sufficient information to ensure that counties are able to screen and refer applicants ineligible for programs within Cal-Health but potentially eligible for other state health care programs;
- Include information about Cal-Health on the joint HFP-Medi-Cal application;
- Prohibit Medi-Cal asset tests for children and adults under Section 1931(b), to the extent allowed by federal or other laws, and
- Require preschools, and public elementary and secondary schools to inform all parents of enrolled children about Cal-Health and allow application to be submitted at these schools, and require providers and urgent and emergency services to inform children admitted for care about Cal-Health.

The bill would also:

- Implement "accelerated enrollment" for pregnant women, beginning one month after federal approval or on July 1, 2009, whichever is later, as permitted by federal and other law;
- Eliminate (centralized) "single point of entry" for accelerated HFP and Medi-Cal enrollment of children and pregnant women, and, instead, require 58 (decentralized) counties to perform these functions and coordinate with Medi-Cal's enrollment broker for case management.

**New status since last board meeting*
***New bill since last board meeting*

***SB 1522** (Steinberg) Health care coverage: coverage choice categories.
Version: Amended 04/17/2008
Sponsor: Health Access
Status: 05/22/2008-Set for hearing in Senate APPROPRIATIONS. In suspense file.

This bill would require the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) by April 1, 2009 to jointly adopt regulations to develop systems to categorize all full-service (non-specialized) health plan contracts and health insurance policies offered and sold to individuals (non-group coverage) into five coverage benchmark categories. It would require each full-service health plan and insurer offering individual coverage to offer at least one contract or policy in each coverage category and meet various standards for price, benefits, type of product (HMO, PPO, EPO, POS, tradition indemnity model, etc.). The bill would require that full-service health plans and insurers be given flexibility in establishing provider networks for the new products as along as they meet access to care standards and other specified requirements. The bill also includes other related requirements for full-service health plans and insurers regarding the pricing of products and their regulation. It would require that all individual health plan contracts sold on or after January 1, 2009 to contain a maximum limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered benefits. DMHC and CDI would be required to annually report on the contracts and policies offered in each category and enrollment. Every three years, the DMHC and CDI would be required to determine if the categories should be revised to meet consumer needs.

***SB 1525** (Kuehl) Health care service plans: onsite medical survey.
Version: Amended 04/24/2008
Sponsor: Author
Status: 05/13/2008- Held as ASSEMBLY DESK.

Existing law requires the Department of Managed Health Care to survey health plans' procedures for obtaining health services, regulating utilization, and assuring quality of care. This bill would add a requirement that the DMHC also review health plan procedures for making determinations of medical necessity. It would also require plans and insurers to respectively report to DMHC or the California Department of Insurance (CDI), and, upon request, to enrollees and providers the rates of initial delays, denials, or modifications of health care services or payments, and the specific rates due to denied, delayed or modified services being medically unnecessary or uncovered benefits.

***SB 1540** (Correa) Health care coverage: children.
Version: Amended 04/23/2008
Sponsor: Author
Status: 05/12/2008-Senate RULES

This bill states the intent of the Legislature to launch a pilot program in Orange County to improve health care services to children's dental health, early developmental screenings and intervention, and to immunization. Provisions of the previous version of this bill regarding details about the pilot program were deleted.

**New status since last board meeting*
***New bill since last board meeting*

***SB 1553** (Lowenthal) Health care service plans.
Version: Amended 04/23/2008
Sponsor: California Society of Clinical Social Work, California Association of Marriage and Family Therapists
Status: 05/22/2008-Set for hearing in Senate APPROPRIATIONS. In suspense file.

The bill would delete the ability of a health plan to retrospectively modify, delay, or deny health care services to an enrollee except due to fraud committed by a provider or subscriber. It would require plans to report to the Department of Managed Health Care (DMHC) at least twice a year the number, reasoning, and timeframes for denying services or denying or modifying reimbursement for services. Current law permits, but this bill would require, the DMHC Director to assess penalties against a plan for not complying with requirements related to delaying or denying care. It would expand the scope of the DMHC's independent medical review system to allow health care providers to participate in addition to enrollees. It would require mental health plans and other plans offering mental health services to file continuity of care policies with the DMHC by March 31, 2009, and would define standards for the content of such policies. It would also require the DMHC to conduct onsite medical surveys every two years instead of "periodically" and would require mental health care professionals to be included on the team of personnel who evaluate plans' care. It would delete a cap on civil action penalties for violations of the Knox-Keene Act, currently $2,500 per violation, giving greater discretion to the DMHC Director. It would expand the 24-hour access-to-care requirements that currently exist for full-service plans to also include mental health plans.

***SB 1593** (Alquist) Health care coverage: children.
Version: Amended 05/07/2008
Sponsor: TBD
Status: 05/22/2008-Set for hearing in Senate APPROPRIATIONS.

This bill would require MRMIB and the Department of Health Care Services (DHCS) to develop a process for transitioning children under age 19 from coverage in Children's Health Initiatives (CHIs) into enrollment in Healthy Families or Medi-Cal and would create a fund for this purpose. It is contingent on enactment of legislation during the 2007-08 Regular or Extraordinary Session that would expand eligibility "at or below 300 percent" of FPL in HFP or Medi-Cal. It would also limit children covered through this bill to those currently enrolled in CHIs. It would require the MRMIB to administer the fund created by this bill. It would require the fund moneys to be distributed by July 1, 2009 to CHIs using a formula the MRMIB, children's advocates and CHIs would jointly develop. It would allow the MRMIB to adopt emergency regulations to implement the transition of children from CHIs into HFP or Medi-Cal.

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***SB 1622** (Simitian) California Health Benefits Service Program.
Version: Amended 03/25/2008
Sponsor: American Federation of State County Municipal Employees
Status: 05/22/2008-Set for hearing Senate APPROPRIATIONS. In suspense file.

This bill would create the California Health Benefits Service Program (CHBSP) within the Department of Health Care Services (DHCS) to identify barriers and incentives to establishing joint-ventures between local initiatives, local health plans, county organized health systems (COHS) and county health authorities with the County Medical Services Program (CMSP). The CHSBP would include six members appointed by the DHCS Director, representing CSMP, health care providers, employers, and COHS, and would report findings to the Legislature by January 1, 2009 and then annually. The bill would require all joint ventures to be licensed by the Department of Managed Health Care (DMHC). The DMHC would be allowed flexibility in issuing new, modified or combined licenses to local initiatives or COHS in order to contract with the Managed Risk Medical Insurance Board or to provide coverage in individual or group markets.

***SB 1634** (Steinberg) Health care coverage: cleft palates.
Version: Amended 04/23/2008
Sponsor: California Society of Plastic Surgeons
Status: 05/14/2008-Senate FLOOR third reading.

This bill would require health plans and health insurers, on or before January 1, 2009, to cover medically necessary orthodontic services for cleft palate procedures upon prior authorization and completion of the utilization review processes.

**New status since last board meeting*
***New bill since last board meeting*

Managed Risk Medical Insurance Board
Bills No Longer Being Tracked

Note: Reflects information available as of 05/20/2008.

AB 2644 (Huff) Medical billing.
Version: Introduced 02/22/2008
Sponsor: Author's constituent
Status: 05/06/2008-Assembly HEALTH. Failed Deadline.

The author is no longer moving this bill forward. This bill would require any health care provider directly billing a patient for professional health care services, including hospital services, to provide a description in "plain English" of the medical procedure or services for which a patient is billed. The bill also would define "plain English" as including "at least one, but not more than five, lay terms."

AB 2653 (Garcia) Hospital access pass.
Version: Amended 04/09/2008
Sponsor: Molina Healthcare
Status: 04/10/2008-Assembly HEALTH.

The author is no longer moving this bill forward. This bill would allow a health plan participating in Healthy Families or Medi-Cal to request from MRMIB or Department of Health Care Services (DHCS) a "hospital access pass," a waiver of Knox-Keene Act geographic accessibility standards, after the end of 120 consecutive days of "good faith" efforts between a plan and a hospital to negotiate a contract. The bill would require hospitals to allow access to any member of a participating health plan if MRMIB or DHCS approves the waiver, unless the hospital elects to forfeit its status as a Medi-Cal provider. The bill would require that hospital services provided to subscribers be reimbursed at area prevailing rates set by the California Medical Assistance Commission. It would require MRMIB or DHCS to grant the hospital access pass unless the hospital, within 15 days of the request for an access pass, can demonstrate that the plan acted in "bad faith." It would define "hospital" as the "sole hospital provider offering one or more medically necessary hospital services within a plan's service time and mileage guidelines," as stated in Knox-Keene Act regulations. The hospital access pass would last for 1-year and would be renewable if a contract is not reached within this timeframe.

SB 1669 (McClintock) Health care coverage: waivered conditions.
Version: Introduced 02/22/2008
Sponsor: Author
Status: 04/16/2008-Senate HEALTH. Failed passage.

This bill failed to meet the deadline for passage out of the Health Committee. Under current law, individual health care service plans and health insurers that cover one or two individuals and do not have blanket pre-existing condition exclusions may, for 12 months following the start of coverage, exclude coverage for specific, individually listed, "waivered medical

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conditions” for which medical attention was sought up to 12 months prior to coverage. This bill would permit these plan contracts to exclude for any length of time a waivered condition for which medical attention was recommended or received during the 10 years prior to coverage.

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